

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 02-20	2. STATE Louisiana
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE October 1, 2002	

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.253 and 447.45	7. FEDERAL BUDGET IMPACT: a. FFY <u>2003</u> <u>\$0.00</u> b. FFY <u>2004</u> <u>\$0.00</u>
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A, Item 1, Page 10j(2)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Same (TN 02-16)

10. SUBJECT OF AMENDMENT: **This is a technical amendment to insert language which was inadvertently omitted from TN 02-16. TN 02-16 supersedes TN 02-13 and not TN 01-10.**

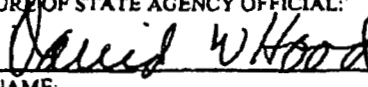
11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☒ OTHER, AS SPECIFIED: **The Governor does not review state plan material**

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

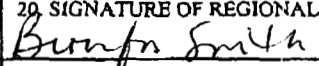
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: State of Louisiana Department of Health and Hospitals 1201 Capitol Access Road PO Box 91030 Baton Rouge, LA 70821-9030
13. TYPED NAME: David W. Hood	
14. TITLE: Secretary	
15. DATE SUBMITTED: December 19, 2002	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/23/02	18. DATE APPROVED: 1/23/03
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/1/02	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: CHARLENE BROWN	22. TITLE: Deputy Director, CMSO

23. REMARKS:

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM****ATTACHMENT 4.19-A
Item 1, Page 10j(2)****STATE OF LOUISIANA****PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES****METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT HOSPITAL CARE**

- 3) DSH payments to small rural hospitals are prospective and paid once per year for the federal fiscal year. Payment is equal to each qualifying hospital's pro rata share of uncompensated costs as defined in I.D.2.f. for the hospital's latest filed cost report for all hospitals meeting these criteria multiplied by the state appropriation for disproportionate share payments allocated for this pool of hospitals. If the cost reporting period is not a full period (twelve months), actual uncompensated cost data for the previous cost reporting period may be used on a pro rata basis to equate to a full year.
- 4) A pro rata decrease necessitated by conditions specified in I.D.2.a. above for hospitals described in this section will be calculated based on the ratio determined by dividing the hospitals' uncompensated costs by the uncompensated costs for all qualifying hospitals in this section, then multiplying by the amount of disproportionate share payments calculated in excess of the federal DSH allotment or the state DSH apportioned amount. No additional payments shall be made after the final payment for the state fiscal year is disbursed by the Department. Recoupments shall be initiated upon completion of an audit if it is determined that the actual uncompensated care costs for the state fiscal year for which the payment is applicable is less than the actual amount paid.

TN# 02-20 Approval Date JAN 23 2003 Effective Date OCT 1 2002
Supersedes
TN 02-16